HOSPITAL MEDICAL ASSISTANCE REIMBURSEMENT

9500.1090 PURPOSE AND SCOPE.

Parts 9500.1090 to 9500.1155 establish a prospective reimbursement system for inpatient hospital services provided under medical assistance.

All provisions of parts 9500.1090 to 9500.1155, except part 9500.1155, subpart 6, shall apply to general assistance medical care substituting the terms and data for general assistance medical care for the terms and data referenced for medical assistance.

Effective January 1, 1987, reimbursements for medical assistance shall be partitioned into reimbursements for persons determined eligible for Aid to Families with Dependent Children or Aid to Families with Dependent Children extended medical coverage and for persons determined eligible for medical assistance on some other basis, including persons eligible because of receipt of Supplemental Security Income and Minnesota Supplemental Aid and persons eligible as medically needy.

MS s 256.969 subd 6

10 SR 227; 11 SR 1688; 13 SR 1689

9500.1095 STATUTORY AUTHORITY.

Parts 9500.1090 to 9500.1155 are authorized by Minnesota Statutes, section 256.969, subdivisions 2 and 6. Parts 9500.1090 to 9500.1155 must be read in conjunction with Titles XVIII and XIX of the Social Security Act, Code of Federal Regulations, title 42, Minnesota Statutes, chapters 256, 256B, and 256D, and parts 9505.0500 to 9505.0540.

MS s 256.969 subd 6

10 SR 227; 13 SR 1689

9500.1100 DEFINITIONS.

Subpart 1. **Scope.** As used in parts 9500.1090 to 9500.1155, the terms in subparts 2 to 50 have the meanings given them.

Subp. 2. **Adjusted base year cost per admission.** "Adjusted base year cost per admission" means an allowable base year cost per admission cumulatively multiplied by the hospital cost index through a hospital's current year.

Subp. 3. **Admission.** "Admission" means the act that allows a recipient to officially enter a hospital to receive inpatient hospital services under the supervision of a physician who is a member of the medical staff.

Subp. 4. **Admission certification.** "Admission certification" means the determination pursuant to parts 9500.0750 to 9500.1080, 9505.0500 to 9505.0540, 9505.5000 to 9505.5030, 9505.5105, and 9505.1000 to 9505.1040 that inpatient hospitalization is medically necessary.

Subp. 4a. **Aid to Families with Dependent Children or AFDC.** "Aid to Families with Dependent Children" or "AFDC" means the program authorized under title IV-A of the Social Security Act to provide financial assistance and social services to needy families with dependent children.

Subp. 5. **Allowable base year cost per admission.** "Allowable base year cost per admission" means a hospital's base year reimbursable inpatient hospital cost per admission that is adjusted for case mix, excludes pass-through costs and includes the reimbursable inpatient hospital costs of outliers up to their trim points.

Subp. 6. **Ancillary service.** "Ancillary service" means inpatient hospital services that include laboratory, radiology, drugs, delivery room, operating room, therapy services, and other special items and services customarily charged for in addition to a routine service charge.

Subp. 7. **Appeals board.** "Appeals board" means the board that advises the commissioner on a hospital's request for adjustments to reimbursements made under the prospective reimbursement system.

Subp. 8. **Arithmetic mean cost per admission.** "Arithmetic mean cost per admission" means the number obtained by dividing the sum of a set of reimbursable inpatient hospital costs per admission by the number of admissions in the set.

Subp. 8a. **Arithmetic mean length of stay.** "Arithmetic mean length of stay" means (the number of days spent in a hospital for all admissions, including outliers, but excluding days in excess of an outlier's trim point) divided by the number of admissions.

Subp. 9. **Base year.** "Base year" means a hospital's fiscal year ending during calendar year 1981.

Subp. 10. **Budget year.** "Budget year" means a hospital's fiscal year for which a prospective reimbursement system is being determined.

Subp. 11. **Case mix.** "Case mix" means a distribution of admissions in the diagnostic categories.

Subp. 12. **Categorical rate per admission.** "Categorical rate per admission" means the ((adjusted base year cost per admission multiplied by the budget year hospital cost index and multiplied by the relative value of the appropriate diagnostic category) plus the budget year pass-through cost per admission).

Subp. 13. **Claims.** "Claims" means information contained on the inpatient hospital invoices submitted to the department on forms or computer tape by a hospital to request reimbursement for inpatient hospital services provided to a recipient.

Subp. 14. **Commissioner.** "Commissioner" means the commissioner of the Department of Human Services or an authorized representative of the commissioner.

Subp. 15. **Cost outlier.** "Cost outlier" means an admission whose reimbursable inpatient hospital cost exceeds the geometric mean cost per admission for diagnostic category O, under subpart 20 by one standard deviation and diagnostic category W, under subpart 20, by three standard deviations.

Subp. 16. **Cost-to-charge ratio.** "Cost-to-charge ratio" means a ratio of a hospital's reimbursable inpatient hospital costs to its charges for inpatient hospital services.

Subp. 17. **Current year.** "Current year" means a hospital's fiscal year which occurs immediately before that hospital's budget year.

Subp. 18. **Day outlier.** "Day outlier" means an admission whose length of stay exceeds the geometric mean length of stay for diagnostic categories A to N, and P to II, under subpart 20

by two standard deviations or for diagnostic category O, under subpart 20 by one standard deviation.

Subp. 19. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 20. **Diagnostic categories.** "Diagnostic categories" means the list of diagnosis related groups in the diagnostic classification system established under Minnesota Statutes, section 256.969, subdivision 2, according to the diagnosis related groups (DRGs) under medicare with adjustments as follows:

	Diagnostic Categories	DRG Numbers Within the Diagnostic Category
A.	Diseases and Disorders of the Nervous System	(1-35)
B.	Diseases and Disorders of the Eye	(36-48)
C.	Diseases and Disorders of the Ear, Nose, and Throat	(49-74)
D.	Diseases and Disorders of the Respiratory System	(75-97, 99-102)
E.	Diseases and Disorders of the Circulatory System	(103-145)
F.	Diseases and Disorders of the Digestive System	(146-183, 185-190)
G.	Diseases and Disorders of the Hepatobiliary System and Pancreas	(191-208)
H.	Diseases and Disorders of the Musculoskeletal System and Connective Tissues	(209-256)
I.	Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast	(257-284)
J.	Endocrine, Nutritional, and Metabolic Diseases and Disorders	(285-301)
K.	Diseases and Disorders of the Kidney and Urinary Tract	(302-333)
L.	Diseases and Disorders of the Male Reproductive System	(334-352)
M.	Diseases and Disorders of the Female Reproductive System	(353-369)
N.	Pregnancy, Childbirth, and the Puerperium	(376-384)
O.	Newborns and Other Neonates with Conditions Originating in the Perinatal Period	
P.	Diseases and Disorders of the Blood and Blood-Forming Organs and Immunity Disorders	(392-399)
Q.	Myeloproliferative Diseases and Disorders, Poorly Differentiated Malignancy and Other Neoplasms NEC	(400-414)
R.	Infectious and Parasitic Diseases (Systemic or Unspecified Sites)	(415-423)
S.	Mental Diseases and Disorders	(424-425, 427-429, 432)
T.	Substance Use and Substance Induced Organic Mental Disorders (Ages 0-20)	(433, 434, 435)
U.	Substance Use and Substance Induced Organic Mental Disorders (Ages over 21)	(433, 434, 435)
V.	Injury, Poisoning, and Toxic Effects of Drugs	(439-455)
W.	Burns	(456-460)
X.	Factors Influencing Health	

	Status and Other Contacts with Health Services	(461-467)
Y.	Bronchitis and Asthma (Ages 0-1)	(98)
Z.	Bronchitis and Asthma (Ages 2-17)	(98)
AA.	Esophagitis, Gastroenteritis, Miscellaneous Digestive Disorders (Ages 0-1)	(184)
BB.	Esophagitis, Gastroenteritis, Miscellaneous Digestive Disorders (Ages 2-17)	(184)
CC.	Caesarean sections	(370-372)
DD.	Vaginal delivery with complicating diagnosis or operating room procedures	(372,374-375)
EE.	Vaginal delivery without complicating diagnosis or operating room procedures and Normal newborns	(373), (391)
FF.	Depressive neurosis	(426)
GG.	Psychosis	(430)
HH.	Childhood mental disorders	(431)
II.	Unrelated Operating room procedure	(468)
JJ.	Cases which could not be assigned to other diagnostic categories	(469-470)
KK.	Extreme Immaturity	(386)
LL.	Prematurity with Major Problems	(387)
MM.	Prematurity without Major Problems	(388)
NN.	Full term Neonates or Neonates Died or Transferred	(385, 389, 390)

Subp. 21. **Discharge.** "Discharge" means a release of a recipient from a hospital.

Subp. 21a. [Repealed, 13 SR 1689]

Subp. 22. **General assistance medical care or GAMC.** "General assistance medical care" or "GAMC" means the program established by Minnesota Statutes, section 256D.03.

Subp. 23. **Geometric mean cost per admission.** "Geometric mean cost per admission" means the nth root of the product of the reimbursable inpatient hospital costs per admission for n admissions.

Subp. 24. **Geometric mean length of stay.** "Geometric mean length of stay" means the nth root of the product of the number of days spent in a hospital for each admission for n admissions.

Subp. 24a. **Health care financing administration or HCFA.** "Health care financing administration" or "HCFA" means the division of the United States Department of Health and Human Services that administers the medicare and medical assistance programs according to titles XVIII and XIX of the Social Security Act.

Subp. 25. **Hospital.** "Hospital" means an institution that, except for state-operated facilities, is approved to participate as a hospital under medicare.

Subp. 26. **Hospital cost index or HCI.** "Hospital cost index" or "HCI" means a single percentage annually multiplied by the adjusted base year cost per admission or the adjusted base year costs to adjust for inflation.

Subp. 27. **Inpatient hospital service.** "Inpatient hospital service" means a service provided by or under the supervision of a physician after a recipient's admission to a hospital and furnished in the hospital for the care and treatment of the recipient. The inpatient hospital service may be furnished by a hospital, physician, or a vendor of an ancillary service which is prescribed by a physician and which is eligible for medical assistance or general assistance medical care reimbursement.

Subp. 28. **Local agency.** "Local agency" means a county or multicounty agency authorized under Minnesota Statutes as the agency responsible for determining eligibility for medical assistance.

Subp. 29. **Medical assistance or MA.** "Medical assistance" or "MA" means the program established under Title XIX of the Social Security Act and Minnesota Statutes, chapter 256B. For purposes of parts 9500.1090 to 9500.1155, except part 9500.1155, subpart 6, "medical assistance" includes general assistance medical care unless otherwise specified.

Subp. 30. **Medically necessary.** "Medically necessary" means an inpatient hospital service that is consistent with the recipient's diagnosis or condition, and under the criteria in part 9505.0540 cannot be provided on an outpatient basis.

Subp. 30a. **Medically needy.** "Medically needy" refers to the definition under the Code of Federal Regulations, title 42, section 435.4 (2), as amended through October 1, 1985.

Subp. 31. **Medicare.** "Medicare" means the federal health insurance program established under Title XVIII of the Social Security Act.

Subp. 32. **Medicare crossover claims.** "Medicare crossover claims" means information contained on the inpatient hospital invoices submitted to the department on forms or computer tape by a hospital to request reimbursement for medicare eligible inpatient hospital services provided to a recipient who is also eligible for medicare.

Subp. 33. **Metropolitan statistical area hospital or MSA hospital.** "Metropolitan statistical area hospital" or "MSA hospital" means a hospital located in a metropolitan statistical area as determined by Medicare.

Subp. 33a. **Minnesota supplemental aid.** "Minnesota supplemental aid" means the program established under Minnesota Statutes, sections 256D.35 to 256D.43.

Subp. 34. **Non-metropolitan statistical area hospital or non-MSA hospital.** "Non-metropolitan statistical area hospital" or "non-MSA hospital" means a hospital not located in a metropolitan statistical area as determined by Medicare.

Subp. 35. **Operating costs.** "Operating costs" means reimbursable inpatient hospital costs excluding pass-through costs.

Subp. 36. **Outlier.** "Outlier" means a day outlier or a cost outlier.

Subp. 37. **Out-of-area hospital.** "Out-of-area hospital" means any hospital outside of Minnesota.

Subp. 38. **Pass-through costs.** "Pass-through costs" means reimbursable inpatient hospital costs not subject to the HCI.

Subp. 39. **Prior authorization.** "Prior authorization" means prior approval for inpatient hospital services by the department established under parts 9505.5000 to 9505.5030 and

9505.5105.

Subp. 40. **Prior year.** "Prior year" means the hospital's fiscal year immediately before the current year.

Subp. 41. **Prospective reimbursement system.** "Prospective reimbursement system" means a method of reimbursing hospitals for inpatient hospital services on a categorical rate per admission, out-of-area hospital categorical rate per admission, categorical rate per admission for MSA and non-MSA hospitals statewide that do not have admissions in the base year, transfer reimbursement, rate per admission, or rate per day, or a combination thereof, determined by the department in advance of the delivery of inpatient hospital services.

Subp. 42. **Readmission.** "Readmission" means an admission that occurs within 15 days of a discharge of the same recipient. The 15-day period does not include the day of discharge or the day of readmission.

Subp. 43. **Recipient.** "Recipient" means a person who has applied to a local agency and has been determined eligible for medical assistance.

Subp. 43a. **Recipient resources.** "Recipient resources" means that amount of money owed to a provider for a claim under the spend-down provisions of the medically needy coverages of medical assistance.

Subp. 44. **Reimbursable inpatient hospital costs.** "Reimbursable inpatient hospital costs" means those costs allowable under Title XVIII of the Social Security Act for inpatient hospital services.

Subp. 45. **Relative value.** "Relative value" means the arithmetic mean of the reimbursable inpatient hospital cost per admission, excluding reimbursable inpatient hospital costs in excess of applicable trim points in each diagnostic category in relation to the arithmetic mean of the reimbursable inpatient hospital cost per admission, excluding reimbursable inpatient hospital costs in excess of applicable trim points of all admissions in all the diagnostic categories on a statewide basis.

Subp. 46. **Routine service.** "Routine service" means those inpatient hospital services included by a hospital in a daily room charge. Routine services are composed of two broad components: (1) general routine services, and (2) special care units including nursery care units, coronary care units, and intensive care units.

Subp. 47. **Second surgical opinion.** "Second surgical opinion" means the confirmation or denial of the need for a proposed surgery by a recommended second physician as specified in parts 9505.5035 to 9505.5105 and Minnesota Statutes, section 256B.503.

Subp. 47a. **Supplemental security income.** "Supplemental security income" means income acquired under title XVI of the Social Security Act.

Subp. 48. **Total hospital admissions.** "Total hospital admissions" means the total number of acts that allow persons to officially enter a hospital during the base year to receive a service provided under the supervision of a physician and furnished in a hospital by a physician, or a vendor of an ancillary service prescribed by a physician.

Subp. 49. **Total reimbursable costs.** "Total reimbursable costs" means the costs identified in a hospital's base year medicare/medical assistance cost report, Health Care Financing Administration (HCFA) Form 2552, 1981 revision, Worksheet A,

column 7, line 84. The 1981, 1983, and 1985 revisions of the Health Care Financing Administration Form 2552 are incorporated by reference. The forms are available at the state law library, Ford Building, St. Paul, Minnesota, and are subject to frequent change. They are published by Blue Cross and Blue Shield of Minnesota, Medicare, Part A Office, 3535 Blue Cross Road, P.O. Box 43560, St. Paul, Minnesota 55164.

Subp. 50. **Transfer.** "Transfer" means the movement of a recipient after admission from one hospital directly to another.

Subp. 51. **Trim point.** "Trim point" means that number of days or that amount of reimbursable inpatient hospital cost beyond which an admission is an outlier.

Subp. 52. **Usual and customary.** "Usual and customary" means the type of fee charged for a health service regardless of payer.

MS s 256.969 subds 2,6

10 SR 227; 11 SR 987; 11 SR 1688; 12 SR 1617; 13 SR 1689

9500.1105 REIMBURSEMENT OF INPATIENT HOSPITAL SERVICES.

The department shall use a prospective reimbursement system to reimburse hospitals for inpatient hospital services provided to recipients.

MS s 256.969 subds 2,6

10 SR 227

9500.1110 DETERMINATION AND PUBLICATION OF RELATIVE VALUES OF DIAGNOSTIC CATEGORIES.

Subpart 1. Determination of relative values. To determine the relative values of the diagnostic categories the department shall:

A. select all claims for all hospitals statewide for state fiscal years 1983 and 1984;

B. assign each claim from item A to the specific admission which generated the claim except as provided in item C;

C. exclude from item B the following claims:

(1) medicare crossover claims,

(2) claims submitted by out-of-area hospitals, and

(3) claims not reimbursed as of February 28, 1985;

D. determine reimbursable inpatient hospital costs for each hospital's admissions for state fiscal years 1983 and 1984 using each hospital's base year data from the HCFA Form 2552 Worksheet, 1981 revision according to subitems (1) to (4):

(1) determine the cost of routine services by multiplying the routine services charge for each admission identified in item B by the appropriate routine service cost-to-charge ratio determined from the base year medicare/medical assistance cost report, using data from HCFA Form 2552, 1981 revision, Worksheet C,

(2) determine the cost of ancillary services by multiplying the ancillary charges for each admission identified in item B by the appropriate cost-to-charge ratio from the base year medicare/medical assistance cost report, using data from HCFA Form 2552, 1981 revision, Worksheet C,

(3) determine the cost of services rendered by interns and residents not in an approved teaching program for each admission in item B by multiplying the number of days for the appropriate routine services by the per diem cost identified in Worksheet D-2, Part I of the base year, and

(4) sum subitems (1) to (3) to determine the reimbursable inpatient hospital cost for each admission in item B;

E. assign each admission identified in item B to the appropriate diagnostic related group under medicare using a version of the Transfer Tape for ICD-9-CM Diagnosis Related Groups Assignment Software distributed and developed by DRG Support Group Limited, a subsidiary of Health Systems International, Incorporated, or the system in use by medicare, provided that the system of DRG assignment used must be used exclusively and uniformly throughout all determinations of rates and adjudications under parts 9500.1090 to 9500.1155;

F. assign each admission to a diagnostic category;

G. identify outliers for each diagnostic category;

H. for each cost outlier, truncate the cost at the value of the cost outlier trim point;

I. for each day outlier, truncate that day outlier's reimbursable inpatient hospital cost by multiplying (the day outlier's reimbursable inpatient hospital cost by the ratio of the admission's trim point divided by the day outlier's length of stay), and then by multiplying the truncated reimbursable inpatient hospital cost by a factor 'x' determined as follows:

$$X = \frac{\text{[Length of Stay - (0.6 x outlier days)]}}{\text{Total days through the trim point}}$$

When diagnostic category O under part 9500.1100, subpart 20 is used in this formula, the department shall substitute 0.6 in the formula with 0.8.

J. determine the statewide arithmetic mean cost per admission for all admissions by dividing (the total reimbursable inpatient hospital costs for all admissions less the amounts determined in items H and I in excess of the applicable trim point) by the total number of admissions including outliers;

K. determine the statewide arithmetic mean cost per admission for each diagnostic category by dividing (the total reimbursable inpatient hospital costs in each diagnostic category less the amounts determined in items H and I in excess of the outlier trim points) by the total number of admissions in each diagnostic category including outliers; and

L. determine the relative value for each diagnostic category by dividing item K by item J.

Subp. 2. **Redetermination of relative values.** The department shall redetermine the relative values of the diagnostic categories prior to the beginning of each state fiscal biennium. The redetermination of the relative values shall be based on claims from the two most recently completed state fiscal years reimbursed on or before March 1 of the second year of the biennium and the cost-to-charge ratios determined during the base year.

These redetermined relative values shall be the basis of reimbursement for the next biennium.

Subp. 3. **Publication of relative values.** The department shall publish in the State Register the relative values of each diagnostic category at least 30 days prior to the start of a biennium.

MS s 256.969 subds 2,6

10 SR 227; 11 SR 1688

9500.1115 DETERMINATION OF ALLOWABLE BASE YEAR COST PER ADMISSION.

To determine the allowable base year cost per admission the department shall:

A. determine reimbursable inpatient hospital costs for each hospital's base year admissions according to part 9500.1110, subpart 1, item D, substituting the terms and data for base year admissions for the terms and data referenced for state fiscal years 1983 and 1984;

B. subtract from the amount determined in item A the amounts in subitems (1) and (2):

(1) reimbursable inpatient hospital costs for outliers in excess of their trim points as determined for outliers under part 9500.1110, subpart 1, items H and I, and

(2) pass-through costs, except malpractice insurance costs, apportioned to medical assistance based on the ratio of reimbursable inpatient hospital costs as adjusted in subitem (1) to total reimbursable costs;

C. divide the reimbursable inpatient hospital costs as adjusted in item B by the number of base year admissions in each hospital including outliers;

D. adjust item C for case mix as follows:

(1) assign each base year admission a diagnostic category as specified in part 9500.1110, subpart 1, items E and F,

(2) multiply the hospital's number of base year admissions within each diagnostic category including outliers by the relative value of that diagnostic category,

(3) sum the products determined in subitem (2),

(4) divide the sum from subitem (3) by the number of base year admissions including outliers, and

(5) divide the cost per admission as determined in item C by subitem (4).

MS s 256.969 subds 2,6

10 SR 227; 11 SR 1688

9500.1120 DETERMINATION AND PUBLICATION OF HOSPITAL COST INDEX (HCI).

Subpart 1. **Adoption of Health Care Costs.** The most recent Health Care Costs published by Data Resources Incorporated (DRI) is incorporated by reference. The health care costs report is available through the minitex interlibrary loan system. The

report is published monthly.

Subp. 2. **Determination of HCI.** For each calendar quarter the department shall determine the HCI as follows:

A. For each calendar quarter obtain from Health Care Costs published by Data Resources, Inc., inflation estimates for the following operating costs:

(1) salaries

(2) employee benefits

(3) medical fees

(4) raw food

(5) medical supplies

(6) pharmaceuticals

(7) utilities

(8) repairs and maintenance

(9) insurance (other than malpractice)

(10) other operating costs

B. During the fourth quarter of each calendar year, obtain data for operating costs as found in the aggregate of hospitals in Minnesota which indicate the proportion of operating costs attributable to each of item A, subitems (1) to (10). These proportions will be used in the determination of the HCI for the next calendar year.

C. Multiply each proportion for item A, subitems (1) to (10) by each subitem's inflation estimate.

D. Sum the products determined in item C and round the sum to one decimal place.

Subp. 3. **Publication of HCI.** The department shall publish the HCI in the State Register 30 days prior to the start of each calendar quarter. A hospital whose budget year starts during a given calendar quarter is subject to the HCI published 30 days prior to the start of that quarter.

MS s 256.969 subds 2,6

10 SR 227

9500.1125 DETERMINATION OF CATEGORICAL RATE PER ADMISSION FOR A MINNESOTA HOSPITAL.

Subpart 1. **Pass-through cost reports.** For each hospital's budget year, the hospital shall submit to the department a written report of pass-through costs, total charges billed to all payers for inpatient hospital services, total admissions for all payers, total days of inpatient hospital services for all payers, total Medical Assistance AFDC admissions, and total general assistance admissions. A pass-through cost report for a hospital budget year that begins on or after July 1, 1987, must separate medical assistance admissions data into AFDC or non-AFDC admissions data. Pass-through cost reports must include actual data for the prior year and budgeted data for the current and budget years. 'Pass-through cost reports are due 60 days before the start of each hospital's budget year and must include the following information: